Oregon Department of Human Services
Office of Developmental Disabilities

In the Matter of **NATIONAL MENTOR SERVICES, LLC, dba MENTOR OREGON** Respondent.	Order of Immediate Suspension & Right to Request a Hearing

TO: Yvette Doan, Authorized Representative
11010 SE Division St., Suite 300
Portland, OR. 97226

The Department of Human Services (DHS) is the state agency charged with licensing Residential Facilities under ORS 443.400 to ORS 443.455 and Oregon Administrative Rules (OAR) Chapter 411, Division 325.

Mentor Oregon, (Respondent) is licensed to operate a 24-Hour Residential Services home at 154 Civil Bend in Winston, OR. 97496.

Respondent is responsible for the operation of the facility and the quality of care rendered in the facility, OAR 411-325-0010(1). Respondent is also responsible for the supervision, training, and overall conduct of the staff when acting within the scope of their employment, OAR 411-323-0030(1)(d).

Based on the statement of violations set forth below, DHS immediately suspends Respondent's license.

STATEMENT OF VIOLATIONS

DD Licensing staff conducted a 120-day onsite review of Mentor Oregon's 24-Hour Residential home located at 154 Civil Bend on March 20, 2019 and found the program out of compliance. Findings include, but not limited to, the following Oregon Administrative Rules (OAR) violations:

Violation 1: Failure to ensure personnel practices were implemented.

STATEMENT OF FACTS: Mentor Oregon was not in compliance with personnel practices:

• It was unable to be determined if the agency inquired about founded reports of child abuse or substantiated adult abuse as there were no applications made available for review during the inspection for three staff. These same three staff had no date of hire documented or signed job descriptions.

• It was unable to be determined if two staff were 18 years or older as applications were not made available to review during this inspection as well as drivers licenses to verify age. There was also no documentation for these two staff to indicate reference checks had been completed or that staff provided applicable information/signed I-9 Forms.

• There was no documentation provided during the onsite review that one staff had 12 hours of annual training or received First Aid/CPR training. There was no documentation provided during the onsite review to indicate two staff had received training over confidentiality.

• There was no documentation found to indicate that one staff had received training over an individual's Individual Support Plan (ISP) and corresponding support documents.

• There was no documentation provided during the inspection to indicate that five staff had completed the Tier 1 and Tier 2 Core Competency Based Training.

CONCLUSION OF LAW: Licensee failed to provide an application for employment or inquire whether an applicant has had a founded report of child abuse or substantiated adult abuse in violation of **OAR 411-325-0025(3)**. Licensee also failed to ensure general staff qualifications were met, violating **OAR 411-325-0025(6)(a)(b).**

Violation 2: Failure to ensure care that promotes the health and well-being of the individual.

STATEMENT OF FACTS: The following violations were identified by DD Licensing staff during an onsite review conducted on March 20, 2019:

• There was no tracking in place to indicate the Dehydration Protocol for an individual was being implemented and followed to alert staff to potential signs and symptoms of dehydration in the individual. The protocol indicated that staff were to ask the individual every 2 hours (awake hours) if he/she would like a drink. There was no tracking in place for this preventative measure. Additionally, the protocol indicated that a sign/symptom of dehydration in the individual would be refusal/missed fluids 2 to 3 meals in a row. There was no documentation found to reflect that the individual's fluid was being tracked at meals and/or every 2 hours to alert staff to this sign/symptom of dehydration.

• The unreported pain and illness support strategy located in an individual's Safety Plan was not being implemented to alert staff to possible unreported pain/illness. The strategy indicated that the program would ask the individual how he/she was feeling throughout the day, but there was no documentation found to indicate this practice was occurring.

• Supports were not developed and it was unclear if identified risks were adequately addressed. Documentation was found that an individual required an IV for dehydration. No Dehydration Protocol was found in place for this identified risk. The program addressed this risk in the Safety Plan that indicated staff were to track the individual's fluid intake and the offering of fluids at a minimum of every two hours. No documentation was found to show that staff offered fluids every two hours as directed by the Safety Plan. Additionally, no supports were found to indicate what the minimum amount of fluid the individual was to consume daily to prevent dehydration or directions for staff if he/she did not meet this minimum.

CONCLUSION OF LAW: Licensee failed to ensure the health status and physical conditions of individuals were monitored in order to take action in a timely manner, in violation of **OAR 411-325-0120(2)(a)(C).**

Violation 3: Failure to ensure physician orders and implementation.

STATEMENT OF FACTS: DD Licensing identified the following violations during an onsite review conducted on March 20, 2019:

• An individual had medications on the Medication Administration Record (MAR) and in the medication storage container without corresponding physician orders. Examples include:

- Cyclobenzaprine listed on the MAR for December 2018 without a corresponding physician's order. This medication had been administered to the individual.
- The individual had an Asper creme Lidocaine patch without a physician's order.

• An individual had physician orders that were not implemented. Examples include:

- The individual had an order from the physician to discontinue the use of Methocarbinal as of 1/8/19, however, Methocarbinal continued to

be on the Medication Administration Record (MAR) and staff documented that the medication was administered to the individual.

- The individual had a physician's order for Omeprazole, originally the order was implemented daily per the MAR for February through March 11, 2019. There was no documentation that the medication had been administered after 3/11/19 and no discontinuation order from the physician was found.
- The individual had a physician's orders for Ranitidine BID PRN for GERD and Solonpas topical patch PRN for back pain. It was observed that the medications were in the individual's medication bin, but had not been implemented on the MAR.
- The individual had a physician's order for Voltaren gel, the order had originally been implemented on the MAR in January and February 2019, the medication and order was no longer on the MAR for March 2019 and there were no discontinuation orders found from the physician.

CONCLUSION OF LAW: Mentor Oregon did not ensure the program had physician order's for medication's or that the physician orders were implemented and or followed, violating **OAR 411-325-0120(2)(b)(A) and (2)(c).**

Violation 4: Failure to ensure Medication Administration Record was complete and accurate.

STATEMENT OF FACTS: Based on observation and record review, it was determined that the program did not ensure the Medication Administration Record (MAR) was complete and accurate for both individuals reviewed. Findings include:

• The transcription for an individual's Amlodepine was not transcribed accurately on the MAR. The 180 Day physician order indicated the

medication was to be administered daily at 8am, however, the MAR indicated it was to be administered at 8pm instead.

• An individual had PRNs administered per staff initials on the MAR, but there was no corresponding documentation as to the reason a PRN was administered nor the effectiveness of the PRN. Examples include:

- Cyclobenzapine PRN administered did not have a reason why the PRN was administered, nor the documented effectiveness of the medication.
- Naproxen PRN administered did not have a reason why the PRN was administered, nor the documented effectiveness of the medication.
- Voltarin 1% gel PRN did not have a reason why the PRN was administered, nor the documented effectiveness of the medication.

• There were blanks on an individual's MAR without documentation as to the reason for the irregularity. Examples include:

- Sertraline and Lisinopril were left blank on 12/7/18.
- Blood pressure every Thursday was left blank on the MAR.

• No MARs could be found for an individual for the months of November 2018 and December 2018.

CONCLUSION OF LAW: Licensee failed to ensure the Medication Administration Record was complete and accurate in violation of **OAR 411-325-0120(3)(b)(A-J).**

Violation 5: Failure to complete Incident Reports

STATEMENT OF FACTS: Based on record review, it was determined that the program did not ensure Incident Reports (IRs) were complete for both individuals reviewed. Findings include:

• Incident Reports (IRs) for an individual were not complete. Examples include:

- An individual had an IR that did provide a detailed account of the incident. The IR indicated that the individual got escalated about not having their way, locked themselves in their bedroom, staff used their key to go in and then the individual yelled/hung up on a supervisor and reported he/she hit themselves 2x. It was unclear how the individual was escalated and/or what the incident was about. Additionally, there was no documented reason why staff entered the individual's bedroom without permission, nor was there a documented administrative review to explain the IR and a plan prevent a recurrence of the incident.
- An IR for an individual did not have a documented administrative review that addressed a plan to prevent a recurrence of the incident. An individual had an IR where the staff had the individual accompany them when the individual's housemate left the supervised setting. The individual and staff followed the housemate in the vehicle and into a store. While in the store the housemate called 911 and reported the staff and the individual for stalking. The housemate then proceeded to physically aggress on staff, at one point the individual put themselves between the staff and the housemate. Afterwards the individual experienced PTSD and started to shake/get angry.
- An IR for an individual did not have an administrative review that involved a plan to prevent a recurrence of the incident. There was an IR for an individual that indicated he/she reported he/she had fallen 2 days prior, his/her knee was hurting and he/she wanted to go to urgent care for an X-ray.

• Incident Reports (IRs) for an individual were not complete as required. Examples include:

- An Incident Report for an individual indicated that he/she had fallen and was taken to urgent care with his/her housemate, due to a possible broken nose. Documentation was found that the individual

went to the emergency room on two separate visits, however, only one IR was located which did not include the second emergency room visit.
- It was noted that the individual left supervised settings and was placed on a 24-hour community restriction. No corresponding Incident Reports were located.

• No plan to prevent a reoccurrence was found for seven of an individual's incident reports.

CONCLUSION OF LAW: Licensee failed to ensure Incident Reports were complete in violation of **OAR 411-325-0190(4)(a) and (b).**

Violation 6: Failure to implement Behavior Supports.

STATEMENT OF FACTS: Based on record review, it was determined that the program failed to complete the Functional Behavior Assessment (FBA) and Positive Behavior Support Plan (PBSP) process as required for one of the individuals reviewed. Findings include:

• The Functional Behavior Assessment did not include the following:
- An explanation of how the behavior was impacted by the Intellectual and/or Developmental Disability;
- Documentation of who made known medical or mental health diagnoses and when these were last affirmed;
- An assessment of the behavior in all environments the individual commonly engages;
- Current ability to accomplish ADLs and IADLs and other health related tasks with current supports;
- Specialized supports that might be beneficial to addressing the behavior and the behaviors that the ISP team and individual want addressed.

• The Positive Behavior Support Plan did not include the following:

- Identification of the setting the individual resides as well as other environments the individual commonly interacts;
- Circumstances that prevent the individual from accomplishing ADLs, IADLs and other health related tasks including an explanation of what hindering the individual from being able to accomplish these tasks;
- An explanation of why past strategies was identified as inappropriate or ineffective;
- A strategy to phase out professional behavior services;
- Documentation that the plan was reviewed with the individual and Designated Persons;
- Documentation that the Behavior Professional provided the initial training of the behavior supports in the PBSP to Designated Persons and sources used as references.

• The individual's PBSP contained intervention strategies that were threatening in nature. The PBSP indicated that when the individual was engaging in target behaviors, staff were to inform the individual that they would have to document the target behavior and any new group homes that the individual wanted to move to would see the behaviors.

• The individual's Positive Behavior Support Plan was not complete or clear, findings include:

- The reactive strategies in this PBSP for physical aggression direct staff: "If unable to maintain health and safety because behavior has lasted for an extended period of time, call 911." It is unclear how long the behavior must last for staff to call 911. Additionally, it is unclear what the length of time has to do with the seriousness of the individual's behavior directing staff to contact 911.
- The reactive strategies section for extreme food and liquid seeking indicated that if the individual was successful in consuming "large amounts", staff were to determine if the substance was hazardous. If

staff were unsure what was consumed or if they know it was a chemical substance, staff were to contact poison control and follow their instructions. It was unclear why this was only pertaining to the individual consuming large amounts of a substance. It was also unclear if this was a risk for the individual as there was no documentation found in the remainder of the individual's chart that indicated he/she was at risk of ingesting non-edible objects or misuse of chemicals.

• The individual's PBSP was not updated to reflect their current placement. The reactive section of the suicidal threats section of this PBSP directed staff to call Yamhill County Mental Health in the event that the individual would not talk with staff. The individual no longer lives in or receives services from Yamhill County Mental Health.

• The individual's Positive Behavior Support Plan was not implemented as directed, findings include:

- The proactive section of the individual's PBSP indicated that proactive measures were: differential reinforcement of other (positive) behaviors, cause and effect utilizing flash cards, solving social problems using 30 common social stories, friend vs bully utilizing flash cards, feedback with the manager three times per week, staff modeling effective boundaries, staff modeling effective communication, the completion of a daily schedule, priming and one on one check ins with staff for a minimum of 10 - 15 minutes every hour. No documentation was found that any of these proactive measures were being tracked, thus it was impossible to determine if these measures were implemented as directed. Additionally, staff indicated the program did not have the flash cards for cause and effect and friend vs bully and the program did not have the 30 common social stories that were referenced in the PBSP.
- The proactive section of the individual's PBSP indicated that after a behavioral incident, staff were to cue him/her to document the

behavior when back at baseline. Staff indicated that this was not implemented.

- The PBSP indicated that all tracking was to be completed in the Therap system. The agency does not utilize Therap and instead utilized a program called iServe. When asked about tracking for the PBSP, staff indicated that it was all contained within the progress notes. No progress notes could be located between 11/26/18 (entry to the program) and 1/14/19. Additionally, it was noted that the progress notes did not contain documentation of all of the individual's behaviors or any proactive measures that were utilized for him/her, making it unclear if this was the documentation source for the individual's behavior tracking.

CONCLUSION OF LAW: Failure to deliver Professional behavior services and behavior supports in accordance with OAR 411-323-0060 is a violation of **OAR 411-325-0350(1).**

Violation 7: Individual Support Plan (ISP) completion and accuracy.

STATEMENT OF FACTS: Based on observation, interview and record review, it was determined that the program did not ensure documentation for the Individual Support Plan (ISP) was complete and accurate for both individuals reviewed. Findings include:

• The Financial Plan for an individual was unclear. The plan indicated that the individual was independently responsible for $500 and did not need corresponding receipts for how the money was spent, however, the plan went on to specify that the individual required documented ISP team approval for any amount spent over $50 for an item. Staff indicated that the protocol was not accurate and did not make sense.

• The Safety Plan for an individual was not complete. Examples include:

- The strategy for an individual's risk of unreported pain/illness was not complete. The strategy did not include signs and symptoms of unreported pain/illness, how the staff were to intervene or where to document signs and symptoms of unreported pain/illness along with the follow-up response by staff.
- The injury due to falling support strategy did not indicate the individual's ability to get up after a fall and/or the type of assistance staff may provide if the individual was unable to get up after a fall.
- The mental health support strategy did not identify the individuals diagnoses and/or signs and symptoms of the diagnoses that would be exhibited by him/her.

• The Dehydration Protocol for an individual was not clear. Examples include:

- The protocol indicated that if signs and symptoms of dehydration are observed in the individual then staff are to notify the supervisor and document in iServe, but did not specify in what module staff would be required to document in (Incident Report, progress notes, medical tracking, etc.)
- The protocol indicated a sign/symptom of dehydration in the individual would be missed/refused fluids 2 to 3 meals in a row, it was unclear if staff would be alerted to possible dehydration in him/her for missing fluids 2 meals in a row or 3 meals in a row.

• An individual's Financial Plan indicated that receipts were not required for weekly individual spending in the amount of $20, but receipts were required for large purchases. It was observed that the individual had an iPad and staff indicated it was purchased while the individual was at the program, but there was no physical receipt found to account for the purchase found.

• The Risk Management Plan (RMP) and Provider Risk Management Strategies (PRMS) pages of an individual's ISP did not match. The PRMS

page included the risk of daily fluid tracking. This was not found on the RMP page. The RMP page included the risk of safety and cleanliness of the residence. This risk was not found on the PRMS page.

CONCLUSION OF LAW: Licensee failed to ensure documentation for the Individual Support Plan were complete and accurate, in violation of **OAR 411-325-0430(1)(c) and (2)(b) and (c).**

Violation 8: Individual Rights implemented.

STATEMENT OF FACTS: Based on staff interview and record review, it was determined that the program did not ensure the protection and wellbeing of both individuals reviewed. Findings include:

• An individual's privacy and right to control their schedule was not maintained. There was an Incident Report (IR) that indicated the individual was escalated about not having their way and locked themselves in their room. Staff used their key to open the individual's door to his/her bedroom without permission and the individual yelled at staff and hung up on the supervisor. The individual was speaking to the program director regarding his/her frustration at the 24-hour notification of outings he/she wishes to attend. There were no support documents and/or Individually Based Limitations in place to limit the individual's community activity time and/or invade his/her privacy by entering the individual's bedroom without permission.

• An individual's health and safety was not maintained due to staff bringing the individual into a housemate's behavior. There was an IR for the individual where the staff had the individual accompany them when his/her housemate left the supervised setting. The individual and staff followed the housemate in the vehicle and into a store. While in the store the housemate called 911 and reported the staff and the individual for stalking. The housemate then proceeded to physically aggress on staff and the individual put themselves

between the staff and their housemate and afterwards experienced PTSD and started to shake/get angry.

• Supports did not ensure an individual's protection and wellbeing. According to the individual's Positive Behavior Support Plan, if he/she engages in any of the target behaviors, he/she is not allowed to go into the community for 24 hours and the 24-hour clock restarts with the conclusion of each target behavior. No documentation was found to explain why the individual was required to wait 24 hours after the conclusion of the target behaviors to go back into the community. Additionally, no Individually Based Limitation was found in place that indicated this limitation was approved by the individual.

When asked if this element of the PBSP was implemented, staff indicated that this was not implemented, however documentation was found that this was implemented. Additionally, an Incident Report for the individual dated 2/21/19 indicated that he/she was already on a 24-hour community restriction due to the target behaviors from the day before, however no documentation was found that the individual had engaged in any target behaviors on 2/20/19. The Incident Report indicated that the individual must be "safe" until the next day (2/22/19), then he/she could go out into the community again. During this incident, the individual left supervised settings and went to Bi-Mart, City Hall and the Police Department all while walking and refused to go back to the program. While at the Police Department, the police took the individual to the emergency room for suicidal ideation then was released to the program.

• It is unclear if staff have been trained on the entirety of an individual's Positive Behavior Support Plan (PBSP) and if all elements of the plan were implemented. Upon arrival of the review team, the individual greeted the review team and told them how he/she had fallen and broken their nose.

When asked about potential self-injury, staff indicated that the individual was not at risk for self-injury, however the team wasn't sure due to a recent

incident on 3/11/19. An Incident Report for the individual's housemate dated 3/11/19 (there was no incident report found for the individual for this date) indicated that the housemate was going to urgent care to have his/her knee looked at due to ongoing pain. The individual requested to go on this outing and was told by staff that he/she was currently on a community restriction due to engaging in target behaviors. The individual then went outside to smoke and upon returning inside the program, informed staff that they had fallen and needed to go to urgent care as their nose might be broken.

A review of the individual's PBSP showed that he/he was identified as at risk for self-injury with the specifics of this being that the individual intentionally falls to the ground in an attempt to injure themselves, usually in an attempt to seek medical services. No documentation was found that staff was aware of the individual's risk of self-injury and no documentation was found that staff implemented any proactive measures when the individual asked to go on an outing immediately after the housemate indicated the need to go to urgent care.

CONCLUSION OF LAW: Licensee failed to implement the individual's rights, in violation of **OAR 411-318-0010(1)(n).**

ORDER OF IMMEDIATE SUSPENSION

Based on the violations outlined above, DHS suspends Respondent's license pursuant to ORS 443.745(1)(a)(b) & (4), OAR 411-325-0470(2) & (4), and OAR 411-325-0020 (24) for reason of imminent danger to health or safety of individuals exist. **This order is effective immediately.**

NOTICE OF RIGHT TO REQUEST HEARING

You are entitled to a contested case hearing as provided by ORS 183.415. You are entitled to be represented by an attorney at the hearing. Legal aid organizations may be able to assist a party with limited financial resources. **To request a contested case hearing, your request must be in writing and must be received within ninety (90) days from the date this Notice was personally served or mailed to you, based on the Date of Mailing at the top of this document.** A request sent by U.S. mail is "received" on the date it is postmarked. You may also email your request for hearing. Your request should be sent to:

Nicole Winje
ATTN: Hearing Request
Oregon Department of Human Services
Office of Developmental Disabilities
PO Box 14540
Salem, OR 97309

If you submit a request for hearing, you will be notified of the time and place of the hearing. Information on the hearing process will be provided to you in accordance with ORS 183.413(2).

If you fail to request a hearing within the time allowed, request a hearing and later withdraw the hearing request, request a hearing and fail to appear at the time and place set for the hearing, or notify DHS that you will not appear at the hearing and DHS has not rescheduled the hearing, you will be in default. If you are in default, DHS will not hold a hearing and DHS may issue a final order by default based on the record of this proceeding to date (including the information in DHS's files on this matter). In other words, DHS's records to date will automatically become part of the contested case record for the purpose of making a *prima facie* case.

You are also entitled to submit a written request for review within 10 days after notice of the suspension. If a request is made, the director shall review all material relating to the suspension and to the allegation of abuse, neglect, or financial exploitation within 10 days of the request. The director shall determine, based on review of the material, whether or not to sustain the decision to suspend or revoke. You may mail or email your written request for review as indicated above.

You may also request to hold an informal conference with DHS to discuss DHS's action. The conference will be held at a location designated by DHS. If determined to be appropriate by DHS, the conference may be held by telephone. If you would like to participate in an informal conference, send your request in the same manner as indicated above for hearing requests, and clearly state your intent to participate in an informal conference.

AGENCY CONTACT INFORMATION

Questions or requests concerning this notice should be directed to:

Nicole Winje, Compliance Specialist
Oregon Department of Human Services
Office of Developmental Disabilities
PO Box 14540
Salem, OR 97309
Nicole.A.Winje@ state.or.us
Phone: 503-373-1992
Fax: 503-373-2228

Lilia Teninty, Director
Office of Developmental Disabilities

March 26, 2019
Date

NOTE TO MILITARY PERSONNEL: Active duty service members have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For more information, you may contact the Oregon State Bar (800-452-8260), Oregon Military Department (800-452-7500), or the nearest legal assistance office, http://legalassistance.law.af.mil.

cc: Michelle Pardon, Douglas CLCM
24 Hour File

RULES APPLICABLE TO THIS NOTICE

411-325-0020 Definitions and Acronyms
(24) "Suspension" means an immediate temporary withdrawal of the approval to operate a 24-hour residential program or 24-hour residential setting after the Department determines a provider or home is not in compliance with one or more of these rules or the rules in OAR chapter 411, division 323.

OAR 411-325-0025 Program Management
(3) MANAGEMENT AND PERSONNEL PRACTICES. A provider must comply with the management and personnel practices as described in OAR 411-323-0050.
(6) GENERAL STAFF QUALIFICATIONS. Each staff member providing direct assistance to individuals must:
(a) Have knowledge of the ISPs for all individuals and all medical, behavioral, and additional supports required by the individuals; and
(b) Have met the basic qualifications in the Competency Based Training Plan. The provider must maintain and keep current written documentation that the staff member has demonstrated competency in areas identified by the Competency Based Training Plan as required by section (5) of this rule, and that is appropriate to their job description.

OAR 411-325-0120 Medical Services

(2) INDIVIDUAL HEALTH CARE.

(a) A provider must ensure an individual receives care that promotes the health and well-being of the individual as follows:

(A) The provider must ensure the individual has a primary physician or health care provider whom the individual has chosen from among qualified providers. Provisions must be made for a secondary physician or clinic in the event of an emergency.

(B) The provider must ensure the individual receives a medical evaluation by a qualified health care provider no fewer than every two years or as recommended by a physician.

(C) The provider must monitor the health status and physical conditions of the individual and take action in a timely manner in response to identified changes or conditions that may lead to deterioration or harm.

(b) A written, signed order from a physician or qualified health care provider is required prior to the usage or implementation of all of the following:

(A) Prescription medications;

(B) Non-prescription medications except over the counter topical;

(C) Treatments other than basic first aid;

(D) Modified or special diets;

(E) Adaptive equipment; and

(F) Aids to physical functioning.

(c) A provider must implement the order of a physician or qualified health care provider.

(3) MEDICATION.

(b) All medications and treatments must be recorded on an individualized medication administration record (MAR). The MAR must include:

(A) The name of the individual;

(B) A transcription of the written order of a physician or qualified health care provider, including the brand or generic name of the medication, prescribed dosage, frequency, and method of administration;

(C) For topical medications and treatments without the order of a physician or qualified health care provider, a transcription of the printed instructions from the package;

(D) Times and dates of administration or self-administration of the medication;

(E) Signature of the person administering the medication or the person monitoring the self-administration of the medication;

(F) Method of administration;
(G) An explanation of why a PRN (i.e., as needed) medication was administered;
(H) Documented effectiveness of any PRN (i.e., as needed) medication administration;
(I) An explanation of any medication administration irregularity; and
(J) Documentation of any known allergy or adverse drug reaction.

OAR 411-325-0190 Abuse and Incident Reporting
(4) INCIDENT REPORTS.
(a) A provider must complete an incident report for all of the following:
(A) Any allegation of abuse as defined in OAR 411-317-0000.
(B) Death or serious illness, injury, or accident, requiring inpatient or emergency hospitalization.
(C) An individual is away from their home without support beyond the time frames established by their ISP team.
(D) Use of an emergency physical restraint.
(E) Use of a safeguarding intervention or safeguarding equipment.
(F) Unusual incident as defined in OAR 411-317-0000.
(b) An incident report must include all of the following information:
(A) Name of the individual who is the subject of the incident.
(B) Date, time, duration, type, and location of the incident.
(C) Conditions prior to, or leading to, the incident.
(D) Detailed description of the incident, including staff response.
(E) Description of injury if injury occurred.
(F) Name of staff, including their position title, and witnesses to the incident.
(G) Follow-up to be taken to prevent a recurrence of the incident. The use of any emergency physical restraint must be reviewed by an agency's executive director, or as applicable their designee, within two hours of application.

OAR 411-325-0350 Behavior Supports and Physical Restraints
(1) BEHAVIOR SUPPORTS. Professional behavior services and behavior supports must be delivered in accordance with OAR 411-323-0060.

OAR 411-325-0430 Individual Support Plan

(1) A provider must collect and summarize the following information prior to an ISP meeting:
(a) One page profile reflecting, at a minimum, information gathered by the provider at the setting where the individual receives services.
(b) Person-centered Information reflecting, at a minimum, information gathered by the provider at the setting where the individual receives services.
(c) Information about known, identified serious risks.
(2) A provider must develop and share the following information with an individual's case manager and the individual, or if applicable the individual's legal or designated representative, as directed by the individual's ISP or Service Agreement.
(a) Implementation strategies, such as action plans, for desired outcomes or goals.
(b) Necessary protocols or plans that address health, behavioral, safety, and financial supports.
(c) A summary of the provider risk management strategies in place, including title of document, date, and where the document is located.
(d) A Nursing Service Plan, if applicable.
(e) Other documents required by the ISP team.

OAR 411-325-0470 License Denial, Suspension, Revocation, and Refusal to Renew

(1) The Department shall deny, suspend, revoke, or refuse to renew a license where the Department finds there has been substantial failure to comply with these rules or where the State Fire Marshal or the State Fire Marshal's representative certifies there is failure to comply with all applicable ordinances and rules relating to safety from fire.
(2) The Department shall suspend the home license where imminent danger to health or safety of individuals exists.
(3) The Department shall deny, suspend, revoke, or refuse to renew a license where it finds that a provider is on the current Centers for Medicare and Medicaid Services list of excluded or debarred providers.
(4) Revocation, suspension, or denial is done in accordance with the rules of the Department and ORS chapter 183.

(5) Failure to disclose requested information on the application or provision of incomplete or incorrect information on the application constitutes grounds for denial or revocation of the license.
(6) The Department shall deny, suspend, revoke, or refuse to renew a license if the licensee fails to implement a plan of correction or comply with a final order of the Department imposing an administrative sanction, including the imposition of a civil penalty.

OAR 411-318-0010 Individual Rights
(1) While receiving developmental disabilities services, an individual has the right to:
(n) Food, housing, clothing, medical and health care, supportive services, and training;